network celebratory issue
ISSUE 11 APRIL 2005

SMMGP 10 Years On

Looking Back - Looking Forward

celebratory issue **In April 1996 in preparation for the 1st conference of Management of Drug Users in General Practice, SMMGP began life as a simple word-processed newsletter, enthusiastically written and hastily stuffed into 254 envelopes at Brent and Harrow Health Authority. Our IT skills were so poor, I think we actually wrote out the labels by hand. We were employed to develop local GP training and shared care arrangements, but when looking around it seemed like we were not the only area that was struggling with GP involvement. The temptation to network and get involved in sharing, drawing on and furthering good practice around the country proved too great. Initially a small group of 6 people met up for a long evening in a north London home with beer, red wine and high spirits. This heady mix fuelled an ambitious programme for the first Managing Drug Users in General Practice Conference. At the time we anticipated radically developing the involvement of GPs towards improving treatment for drug users – it all felt exciting and just possible.**

The conference and newsletter emerged as ways of networking with new friends in the field; opportunities for GPs and others desiring change and improvement in services, treatment and training, to share experiences, hopes and frustrations. As a first 'group venting', the conference proved to be a passionate and oversubscribed affair. We had lengthy and heated outpourings from the conference floor, overrunning sessions, a shortage of breakout rooms, even some heckling, and many standing delegates due to a shortage of seats. Crammed into the main meeting room of the RCGP in London, it had the feel of a movement being born, and we think it was of sorts. The RCGP had decided to take an unusual or farsighted stance at the time, backing what was widely perceived as unpopular or controversial work.

The frenzy of activity that culminated in the conference and newsletter in 1996 was a turning point. From this point on, practitioner momentum for development and change

...continued overleaf

network
IN THIS ISSUE

The needs of children who live with parents who are problem drug users

"I can't tell my teacher I was late because I was getting my sister ready for nursery, as my mam is a 'smack head' and couldn't get up"

The most recent and substantial influence to our awareness of the effects of parental drug use on children is a report written by the Advisory Council for the Misuse of Drugs, Hidden Harm (2003). The report is wide reaching highlighting risk factors, with recommendations relevant to primary care.

See article pages 2-3

The government response to Shipman 4

The government response to the fourth report of the Shipman enquiry has some important implications for the prescribing of controlled drugs. We have interpreted the 10 major commitments in the government response. Whilst there is to be greater scrutiny over prescribing, a wider range of prescribers will be created, along with better training and seemingly an end to handwriting requirements.

See page 4

…continued from front page

ran parallel with, and just possibly helped in a small way a whole array of policy developments from 1995 onwards. The Executive Letter, 'EL 95 114' on the tips of our tongues in 1995, was a key development as all Health Authorities were urged to encourage the development of shared care arrangements. We have not looked back. The 'orange book' was reviewed, the first national strategies were put in place and gradually the messages of harm reduction, the value of treatment, and the concept of normalizing the care of drug users in general practice took hold. The role of the GP and primary care in the treatment of drug users shifted from a controversial, minority and disputed area, to becoming increasingly considered the norm.

Primary care is now establishing itself as a progressive and accepted central player in drug dependency treatment. A number of factors have supported this including:

- **Acceptance that drug dependence is like so many other chronic relapsing conditions dealt with everyday in general practice.**
- **GPs actually needed very few additional skills and knowledge. GPs were practiced in holistic care. Working with the patient and substitute prescribing proved not to be rocket science.**
- **Maintenance has proved to be the most effective treatment for many patients and this is well suited within the longitudinal health care of general practice.**
- **Peer expertise and leadership had developed. Some GPs were already working with more complex patients presenting in primary care in areas where specialist services were working to capacity with stable patients, unable to take on many new referrals.**

See history of GP involvement article, page 7

Over time, partly though the work of GPs and others in this network, the message that primary care has a lot to offer has stuck. It's now a very different landscape in terms of both service configuration and the role of treatment. Primary care has helped bring a normalising and longitudinal outlook on 'treatment' - or more accurately, caring for drug users. Patients can be viewed as any other patient with health needs, which may include a drug or alcohol problem.

Developments over the last 10 years have certainly shaken things up and created a vibrant momentum. Change has brought some inevitable and temporary tension between primary care and the addiction specialists. The need to see ourselves as one effective and developing system is reasserting itself– if parts of the treatment system are dysfunctional then the system is dysfunctional. Better communication between services, joint meetings between RCGP and RCPsyc, the formation of the Specialist Clinical Addiction Network (SCAN) and a joint roles and responsibilities paper have all helped. We now need a service landscape that links up in all the right places and makes the most of all its features. We feel that the future for primary care drug treatment is bright for both patients and practitioners.

Jean-Claude Barjolin and Dr Chris Ford

The needs of children who live with parents who are problem drug users

"I can't tell my teacher I was late because I was getting my sister ready for nursery, as my mam is a 'smack head' and couldn't get up" (11 year old boy)

The most recent and substantial influence to our awareness of the effects of parental drug use on children is a report written by the Advisory Council for the Misuse of Drugs, Hidden Harm (2003). The report is wide reaching, recommending action across a range of professionals including health, primary care, social services, education and voluntary sector organisations. This report was really the first major report looking at the effect of drug use in parents on their children. The government's response published last month endorsed the vast majority of Hidden Harm's 48 recommendations.

Hidden Harm estimated that there are between 250,000 – 350,000 children living with a problem drug user, which equates to approximately one child per drug user in the UK. The report suggests that 54% of parents who are drug users no longer have their children living with them.

"Last year my mam was using real heavy, I had to ring the ambulance one day because I couldn't wake her up, after that I used to wag school because I wanted to make sure she didn't do it again"

The report's findings are that parental substance use can cause harm to children at every stage of their development from conception to birth. However, it suggests that there are significant ways that this harm can be reduced, such as getting parents into treatment, and that reducing this harm should be a major policy objective. Frequently children who live with problem drug users become "Young Carers ", often caring not only for parents but for younger siblings as well, and the stigma, isolation and fear make life particularly difficult.

Using drugs and /or alcohol does not automatically make someone a bad parent and it is essential not to assume that using substances will invariably have a negative effect on parenting; but we need to recognise when parental use is impacting negatively on a child / children and how to intervene effectively.

Hidden Harm identifies two categories of risk factors for children

1. ***Drug risk Factors***
2. ***Social risk factors***

It also suggests that the more risk factors a parent has, the greater the potential harm to their children.

Drug risk factors

1. ***Problematic drug use*** – Hidden Harm defines this as "drug use with serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them."
2. ***Polydrug use*** – When drug users are using two or more substances together this can greatly increase the unpredictability of the users behaviour which can have a detrimental effect on their children, particularly in households where there is already stress and tension.
3. ***Parental insight into the effects of their drug use on their child*** – Generally speaking, the more honest a parent can be about their drug use particularly in relation to parenting, the better the outcome can be.

4. ***Route of administration*** – Injecting drug users expose themselves to much greater risk of overdose, abscesses and blood borne viruses, which also affects their capacity as parents.

Figure 1 : Proportion of parents living with their children according to number of risk factors present

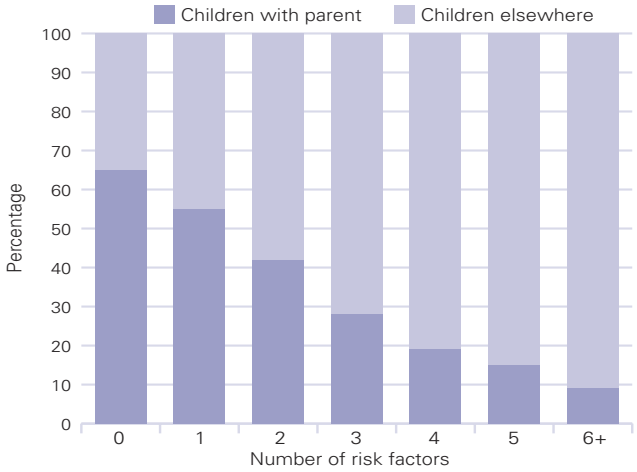
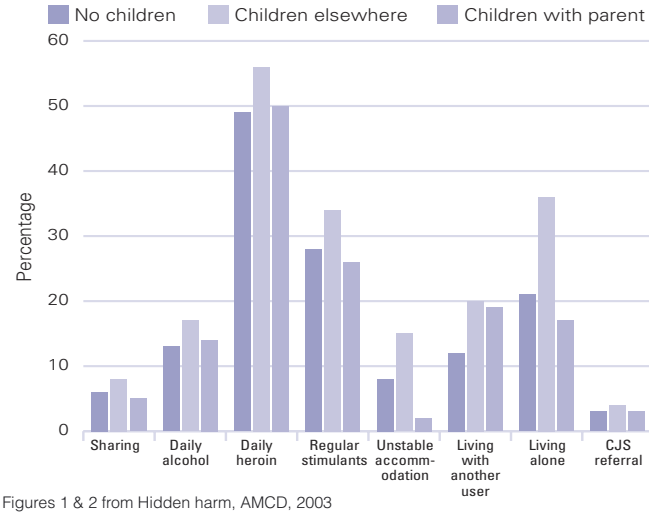


Figure 2 : Parenthood and individual risk factors



Figures 1 & 2 from Hidden harm, AMCD, 2003

Social risk factors

1. ***Unstable accommodation*** – Many problematic drug users have problems with housing. Often they move frequently in and out of poorly maintained private accommodation or short life public housing, and this can have a far more negative impact on children than was previously thought. Regular moves can result in changes in health, education and social services professionals and also in the child's friends. Not only is this unsettling and disruptive for the child, but no professional and / or agency will get to know the family and child well resulting in inconsistency or continuity of care.
2. ***Living alone or with strangers*** – Problem drug users can share accommodation with other drug users who they do not know well, so consequently they do not know the potential risk strangers pose to their children.
3. ***Living with another drug user*** – The risks to children can be increased if all adults in a house are problematic drug users. There will usually be more stability if there is at least one non-user at home.
4. ***Involvement in the criminal justice system*** – This can involve exposure to criminal activity like theft and drug dealing, or the enforced separation of a prison term. It can also include exposure to commercial sex work.

What can primary care do to limit harm to children?

The report suggests that there are a number of 'resilience factors' that can limit the potential impact of harm for the children of drug users. These include:

- Parents being in treatment, resulting in increased stability within the home.
- Regular supportive help from a primary health care team. The strength of primary care is that the relationship is with the whole family, therefore Primary Care staff are uniquely placed to support the children of drug users.
- Multi-agency working. The standard of parenting should be the defining factor in multi-agency working, not the substance use. If you are working with parents who are problem drug users, involve other professionals to help you assess and support the whole family. All cases should be assessed individually, and the Substance use not viewed in isolation.

NB: The Children Act 2004 has not yet been enacted, but is likely to increase the duty on all agencies including health to work together to assess and support children's needs.

The standard of parenting should be the defining factor in multi-agency working, not the substance use.

Hidden Harm makes some specific recommendations for primary care regarding the management of problem drug using parents and their families:

- Ensure that number, age, and whereabouts of the children of drug using patients is being recorded at assessment (NB this is now needed for all children, whether their parents use drugs or not).
- Children of drug or alcohol users should benefit fully from appropriate services including the prevention (including hepatitis B vaccination), diagnosis and treatment of blood borne virus infection.
- Ensure that all problem drug-using patients have access to appropriate contraceptive and fertility advice and management. This should include information about access to services for antenatal care, emergency contraception and termination of pregnancy.

It is likely that most GPs delivering treatment to drug users will already be fulfilling these recommendations, however if you or your local service is not, you should raise this with your Shared Care Monitoring Group/ shared care coordinator/ DAT and/or PCT commissioner. It is the local DAT/ PCT responsibility to support and audit this work, so they will want to be made aware if services are not being provided and should support you to put something in place if necessary.

Annie D Darby, *Specialist Health Visitor – Substance Misuse North East Lincolnshire PCT & DAAT*
Kate Halliday. *SMMGP*

For online copies of Hidden Harm see:
http://www.homeoffice.gov.uk/docs2/hiddenharm.pdf -

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Parental Substance Misuse and Child Welfare
London: Jessica Kingsley Publishers, 2003

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Children's needs – parenting capacity. The impact of parental mental illness, problem alcohol and drug use and Domestic violence on children's development.
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Flexibility and scrutiny in the government response to Shipman 4

The government response to the fourth report of the Shipman enquiry has some important implications for the prescribing of controlled drugs. The government has made 10 major commitments in their response (edited down government response in bold, followed by our interpretation).

1. **All healthcare organisations to appoint a 'proper officer' to monitor controlled drug prescribing and dispensing.** This person is likely to be the Medical Director or Clinical Governance lead although this is not elaborated on. This applies to all healthcare trusts and PCTs.

2. **A similar duty for other local and national bodies such as the police, Health Care Commission (HCC), National Patient Safety Agency and Commission for Social Care and Inspection.** So all agencies that have any contact with controlled drugs will have to do the same.

3. **This should be monitored by the HCC.** An enforcement function.

4. **The DH will work with the General Medical Council, Royal Pharmaceutical Society for Great Britain, General Dental Council and the Nursing and Midwifery Council to produce clear and explicit guidance around good practice with controlled drugs and means of enforcing it. (NB, the government rejected the use of criminal sanctions as recommended).** More good practice guidance but with teeth.

5. **A commitment to legislate to allow other professions, where it is clinically appropriate and safe, to prescribe controlled drugs under similar arrangements.** This is a commitment to bring forward not just nurse prescribing but for other independent prescribers as well, in the first instance this will be nurses and pharmacists but there is scope for this to be widened. It also does not say this has to be supplementary prescribing either. On March 14th the misuse of drugs regulations were changed to allow for supplementary prescribing of controlled drugs and this is now legal, in theory, read the law on. http://www.legislation.hmso.gov.uk/si/si2005/20050271.htm

6. **A commitment to develop the IT necessary for electronic generation of scripts and electronic controlled drug registers. Legislation will be amended to facilitate this.** This looks like the end of the need for handwriting exemptions, this must be positive.

7. **Legislation to require wholesalers, pharmacists and prescribers (including private prescribers) to use standardised electronic or handwritten forms sent to a central body for analysis. Irregularities will be reported to local controlled drug leads for further action as needed.** Looks like big brother will be seriously monitoring all scripts though. However at least private prescriptions can be monitored just like NHS generated ones.

8. **Patient drug record cards (PDRCs) for injectable schedule 2 drugs will be piloted (concerns about practicality).** Probably a non-starter.

9. **A commitment to develop better patient information on handling and disposing of medicines and the legal requirements for controlled drugs.** More patient information leaflets.

10. **The government will work with regulatory organisations and educators to review undergraduate and postgraduate education so that graduating healthcare professionals understand the legal requirements and know how to use controlled drugs appropriately and safely. Also to define competencies for those involved in clinical governance and inspection.** This might see the introduction of more training at undergraduate and postgraduate level on controlled drug prescribing, the field have been asking for this for years.

Additional points on prescribing and dispending from the government response:

- The total amount of controlled drugs on a prescription is to be limited to 28-30 days worth of supply.
- The 'life' of a prescription following its date of issue will be limited to 28 days. Currently CD prescriptions can be dispensed at any time during a period of 13 weeks following their date of issue.
- All controlled drug prescriptions must be on a special distinct pad that uniquely identifies both prescriber and patient.
- The government has given PCTs the responsibility to ensure the safe disposal of unused controlled drugs, but there is also an expectation that the healthcare professional responsible for the patient's care should also have responsibility for tracing unused controlled drugs.
- It will become mandatory for all Controlled Drug Registers to include a running total. This will bring community CD registers into line with those currently used in hospital practice.

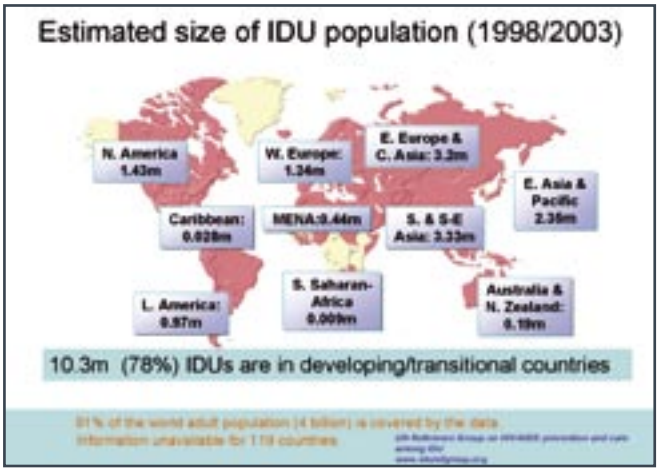
Overall we feel that this has been a reasonably pragmatic response. Whilst it is introducing greater scrutiny over prescribing it is also creating a wider range of prescibers, better training and seems to be ending handwriting requirements. What do you think? Please send us your views.

Jim Barnard,
Primary Care Adviser SMMGP

Harm reduction and drug treatment: a global perspective

Based on presentation at the 3rd UK Treatment Conference February 2005 by Gerry Stimson, edited by Chris Ford

The United Nations Office on Drugs & Crime (UNODC) estimates that about 200 million people consume illicit drugs. Of those 15m are users of opiates (9m heroin), 13m cocaine, 146m cannabis and 38m amphetamine and ecstasy. This is most probably an underestimate. There are an estimated 13.2 million injecting drug users (IDUs) worldwide reported in 136 countries, 10,300,000 (78%) of them are in developing/transitional countries.



Worldwide we know that 136 countries have injecting drug users and 93 of those have HIV infection in IDUs. This is about 10% of global HIV infections. HIV rates vary in North America between 0.4 - 42%; Latin America between 0 - 80%; South & SE Asia 0 - 92.3% and Western Europe between 0 - 66.5%, with Spain & Portugal having some of the highest and the UK the lowest.

The UN has made a strong commitment to harm reduction. For example the UN General Assembly Declaration of Commitment on HIV/AIDS 2001 stated that by 2005 there should be "a wide range of prevention programmes … available in all countries, including male and female condoms and sterile injecting equipment; harm-reduction efforts related to drug use;.."

The WHO/UNODC/UNAIDS position paper on 'Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention' states that: "Substitution maintenance treatment is an effective, safe and cost-effective modality for the management of opioid dependence. Repeated rigorous evaluation has demonstrated that such treatment is a valuable and critical component of the effective management of opioid dependence and the prevention of HIV among IDUs."

Despite this, UNAIDS estimates that less than 5% of IDUs globally have access to treatment or harm reduction or even basic HIV prevention advice. Coverage of needle exchange, substitution treatment and antiretroviral therapy is poor. For example 95% + of methadone globally is consumed in developed countries and substitution treatment is available in few countries outside of Europe, North America and Australasia. There is some in Argentina, China, Croatia, India, Indonesia, Iran, Kyrgystan, Malaysia, Moldova, Nepal, Singapore, Thailand and Ukraine. On a positive note, China has approved the establishment of 1558 MMT clinics covering about 310,000 heroin users in China in the next three years.

Antiretroviral treatment (ARV) for IDUs was only available as of 2003 in 13 countries outside of Europe, North America and Australasia, making only a total of 17,368 (or 2,368 excluding Brazil) treatments.

Summary

Implementation of harm reduction, effective drug treatment, and ARV remains poor for the 80 % of IDUs in developing and transitional countries. Most harm reduction and treatment resources go to 20% of the worlds injecting drug users in rich countries.

Across the globe most injecting drug users receive very little treatment and harm reduction. Rather, the case is that most drug users are subject to penal excess, ineffective treatment, community and extra-judicial violence. They are denied the means to protect themselves from ill health, the right to effective drug treatment, and treatment for HIV and HCV infection.

Furthermore, the USA has now launched an attack on harm reduction, and is pressing UN agencies to withdraw their support for needle exchange [1]. It is essential that all harm reduction, HIV/AIDS, drug policy and drug treatment organisations press UNAIDS, WHO and UNODC to maintain their commitment to evidence based harm reduction and good treatment for drug users.

Editor's note: next edition will feature how we are doing worldwide with primary care drug treatment by Chris Ford.

(1) US pressure on harm reduction

The detailed story of 'The confrontation between zero-tolerance ideologists and harm reduction pragmatists…' can be found at http://www.tni.org/drugs/index.htm - click on 'harm reduction'.

Mind your manners - treating patients well

So far 'Drug and Alcohol Findings' has published two instalments of its 'manners matters' series, written by Mike Ashton (part 1 co-authored by John Witton). This is a robust thematic review of the evidence (mostly UK and US) relating to the ways treatment services operate affecting retention and outcome.

In part 1 they present evidence of the effect of waiting times on treatment outcome. Predictably, waiting longer is shown to have a deleterious effect even for methadone services where there is a more powerful inducement. They quote evidence that rapid intake does not jeopardise long-term retention or outcomes. The importance of the personal touch is then examined. Reminders for appointments, both at assessment and follow up, were a powerful tool but needed to have a personal feel to be most effective - for example a phone call. The merit of intensive and persistent follow up is also shown. Evidence is even presented that a call to someone who has left treatment just asking 'how are you doing' is therapeutic in itself.

In part 2, extra services that can be offered to increase attendance and retention are examined, especially transport and childcare. Help with transport, in particular a driver and vehicle, had been proved to be very effective in this regard. This had the advantage of being both more personal and of providing better access to other services such as housing and employment. Help with childcare has also been found to greatly increase retention, especially in residential rehabilitation programmes. However, help with childcare might be rejected if the carer was unfamiliar or if there was any perceived threat in terms of custody.

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An unrepentant and memorable patient

Looking Back - Looking Forward

A compelling and moving story of a patient who merited much better care. It would seem that over the years we have slowly learnt a few things.

Recently one of my favourite patients died. He was in his fifties and had been using the addiction services for around thirty-five years. I liked him because he was unrepentant about his drug use and uncomplaining about his considerable physical difficulties caused by it, he accepted them as part of his chosen lifestyle. He told me that he had never taken 'street heroin', but had been introduced to opiates by way of injectable vials in the sixties. I decided to review his notes to establish this and although I didn't find the truth, I did find a timeline of service use and how it differs from today.

Our notes started from 1980, there was a mention of an inpatient treatment in 1970 that lasted three months. We have no record of any psychiatric illness, but this I presume was a detox as he was free from drugs for eight years. His next contact was with a consultant psychiatrist when he was taking 300ml of Gees linctus a day. A six-week detox was planned starting with 30mg methadone in 5mg tablets, and a two-week supply was given. He was noted saying at follow up that 'he felt the methadone wasn't as good as the morphine because it didn't make him happy'.

The reduction didn't materialise, but he was given two weekly scripts for methadone tablets for the next two years. Each time he saw the consultant and not the drugs worker, and each time was followed up by a short letter stating that he was using more tablets on top and threatening to cut him down. He was never offered more than 25 mg methadone despite it obviously not being enough.

During this time, the consultant felt that he may have a schizophrenic type illness, based on his ambivalence to his drug use, and by a home visit where he saw his occult books and the nature of his paintings which were described as 'schizoid' (the ones I saw looked like William Blake). He was given pimozide, depixol and chlorpromazine. Initially I feel there was a clash of cultures with the psychiatrist which did not help in the diagnosis of schizophrenic . The consultant could not see how he could spend his money on Gees linctus and the rest on painting materials, neglecting to eat well, and think this was a perfectly acceptable way of life.

In 1982 he was on 5mg prescribed methadone and it's interesting to note that his only period drug free was a self-imposed spell for four months when he fell in love. Later that year he started to use intravenous heroin and Diconal and after a short attempt at detox returned to regular two weekly scripts but never above 25mg. His 'extra' drug intake continued as before. In 1986 he was admitted for a three day 'methadone assessment' in the local psychiatric hospital. This involved taking a series of measurements, blood pressure, pulse, sweating, etc to titrate the amount of methadone a patient needed. It was noted that he wasn't happy with the amount of methadone he was given. Probably he was physically comfortable but not so mentally.

From 1986-1988 he stayed on two weekly scripts and in 1989 was admitted again and discharged on 15ml methadone. At this time he was also developing an alcohol problem. In 1987 things changed significantly as his methadone was increased to 45 ml. In 1996 he was admitted for an alcohol detox and by 1997 his methadone had been increased to 60ml. In 1998 he was admitted for another alcohol detox and in 2000 he was on 80 ml of methadone until his death.

Some aspects of this timeline are familiar; the fact that this man enjoyed and was going to take drugs despite failing health; the descent into alcohol abuse over time although this mainly took off in the latter years. Despite being hepatitis C positive and having severe hypertension for about eight years, he never saw the GP or hospital services. He certainly didn't pick up his anti-hypertensives from us, and should have been on a number of medications. He had a stroke which left him unable to speak well and unable to hold a paintbrush in the last two years of his life. As he was too young for the normal stroke services, his key worker from the addictions unit tended to do more than she should in helping him around the house.

But it's the differences that I found interesting; the fact that he was an inpatient for three months in 1970. He saw, not a drug worker, but a consultant every two weeks for years. For a long time he was given two weeks of tablets at a time. When he had a stroke he could no longer paint, but still had to shuffle to the chemist everyday for his methadone. He also fell between 'two stools' regarding social care because of his substance misuse, a problem likely to grow with an ageing user population. There was the non acceptance that here was a man who had a ' different ' lifestyle, not a mental illness. The under dosing for years of this man seems astonishing in hindsight - could things have been different if he had been stabilised earlier? He underwent numerous detoxes before maintenance was accepted, with titration of methadone then conducted in hospital, not in the community.

During this time he had two children and married twice, the second time to a heroin user. Throughout, he had periods where he worked and had quite serious hopes of being an artist. According to the consultant, his paintings were good, and he had an exhibition once in London. I feel the final irony is that if he had been born 100 years earlier when he could have bought what medication he liked, he may well have become famous.

Dr David Cocks

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The review also quoted evidence on the importance of flexible and realistic opening hours and on the dangers of 'over treatment'. As an example of the latter, they describe those with moderate to mild needs being required to undergo intensive treatment. This was observed predominantly in the criminal justice system, but is probably prevalent in non-criminal justice community settings as well. In one study this was associated with negative outcomes, such as drop out, increased drug use and reduced social prospects.

All the points in parts 1 and 2 Manners Matter were fully backed up by research evidence and case example for illustration.

This series is essential reading for all those providing services for drug dependency, and although much of it would appear to be common sense, common sense does not always prevail in the real world. Both the first two instalments and hopefully subsequent ones can be viewed on the lifeline web-site:
http://www.lifeline.org.uk/
Alternatively subscribe to drug and alcohol Findings:
http://www.drugandalcoholfindings.org/

Jim Barnard, SMMGP

A sentimental, and no doubt slightly flawed historical snapshot of GP involvement in the care of drug users

Looking Back - Looking Forward

In the early part of last century some GPs prescribed what was effectively a form of maintenance as allowed for in the 1926 Rolleston [1] report. Up until the 1960s this prescribing was mainly for small numbers of people, mostly middle class and middle aged, including many doctors and nurses. This freedom of prescribing by doctors which included heroin and cocaine became known as the 'British System'.

With increasing drug use in new patient groups who were often young and unstable, concerns arose of irresponsible prescribing by a small number of doctors. Consequently, the 2nd Brain Committee report in 1965 [2] recommended that specialist centers known as Drug Dependency Units (DDUs), should take a lead headed up by specialist psychiatrists. The right to prescribe heroin and other specified controlled drugs for the treatment of addiction was restricted to doctors licensed by the Home Office. These changes effectively worked as a recommendation for GPs to leave this area of work alone.

Drug use continued increasing, with a notable rise in imported illicit heroin in the 1970's. In spite of the value of maintenance established by Dole and Nyswander [3] in the US, abstinence based approaches tended to prevail within new services from about the 1970s; with what is now considered under-prescribing, emphasis on reducing doses and detoxification, enforced counseling and therapy, and punitive approaches to continued drug use or relapse often resulting in expulsion from services.

In the 1980s, a new significant rise in the number of drug users coupled with the advent of HIV encouraged the establishment of Community Drug Teams (CDTs). This was part of a formal policy shift to reengage GPs in prescribing for and jointly managing the care of drug users. Concerns arose of HIV passing from intravenous drug users into the mainstream population. Drugs policy, or its impact on public health, was no longer of marginal concern. However, CDTs had only limited success with most failing to get widespread GP engagement. Many GPs preferred to still refer drug users to CDTs, generally perceiving them as an extension of the specialist DDUs, leading to many CDTs simply becoming additional prescribing centers.

Abstinence based approaches and increasing demands on treatment centres in the 1970s – 1980s meant that many patients found themselves frequently in and out of services. Some patients with unmet complex health needs circulated in the community, looking for GPs willing to take up the slack. Very gradually an eclectic mix of services and responses including the voluntary sector and a small cohort of experienced and dedicated GPs existed by the late 1980s. But most GPs elected not to get involved. This was still perceived as the work of specialist services, involving an unpopular client group for which GPs had received no formal training to treat. Additionally and importantly, the General Practitioners Committee vociferously argued the work to be outside of General Medical Services.

However since 1995, with renewed policy and grassroots initiatives to review treatment and to reengage GPs through shared care, the picture has changed almost unrecognizably. Harm reduction and patient centered approaches are beginning to prevail. Appropriate dosing whilst not yet the norm is becoming a central policy drive. Maintenance is now accepted as an evidence-based approach which acknowledges opiate dependency for many as a chronic relapsing condition. Maintenance is sensibly placed within a range of treatment options that respect the needs of individual patients and the overall goal of harm reduction.

Now many more GPs are involved in this area of work, with many prescribing as part of shared care schemes. This is now part of accredited and elective contractual work for GPs. Many enhanced, PMS and intermediate GP led services exist. A large cadre of special interest GPs with extensive clinical and service development experience has emerged. National standards and accredited training and support networks exist. The formalisation of GPs working as nationally accredited specialists alongside other addiction specialists is probably not far off in the future. Importantly, the DH and NTA are embracing the active development of services and treatment approaches by general practitioners. The primary care led NHS seems reflected in the progressive involvement of GPs in the substance misuse field.

Jean-Claude Barjolin, SMMGP

Acknowledgements to Chris Ford and Jim Barnard

(1) For further information about the Rolleston Report see:
http://www.exchangesupplies.org/publications/methadone_briefing/section1.html#roll
(2) For further information about the Brain Report see:
http://www.unodc.org/unodc/en/bulletin/bulletin_1962-01-01_2_page006.html
(3) Dole, V.P. and Nyswander, M.E. Methadone maintenance and its implications for theories of narcotic addiction. In: Wikler, A (ed), The Addictive State, p 359-366. Baltimore: Williams and Wilkins, 1968.
Dole, V.P.; Nyswander, M.E. and Kreek, M.J. Narcotic blockade. Archives of Internal Medicine 1966 118: 304-309.

Pharmacy Fix

At last, instalment prescribing of Diazepam in England!!

From 14th April 2005, Diazepam is added to the list of products that can be ordered for dispensing by instalments in England. Scotland have had this since 1988 and Wales since 2001. Previously only buprenorphine and Schedule 2 controlled drugs, such as methadone, could be ordered by instalments. The amendment (SI 2005 No 893) is to the NHS General Medical Service Contracts Regulations 2004 (SI No 291). The Instalment dispensing prescription form can be used only for the purpose of ordering the supply by instalments. The period of treatment is not to exceed 14 days, and the prescriber must specify the number of instalments to be dispensed and the interval between each instalment.

The instalment prescribing of diazepam is something that we have been asking for a long time, making daily pickup of diazepam much easier to implement. This is good news for prescribers, patients and pharmacists!

Clarification of pharmacy obligations to dispense

A point of clarification regarding our last Network 10 Pharmacy Fix article. It stated that "As the supply of substitute medications for the treatment of opiate dependence are not part of NHS General Pharmaceutical Services contract, a pharmacist is under no obligation to dispense methadone or buprenorphine (They are obliged to dispense it if the NHS script is for organic disease i.e. pain)...." On checking with the Pharmaceutical Services Negotiating Committee (PSNC), Martin Bennett, the pharmacy representative on SMMGP, confirmed with Stephen Lutener, Head of Regulation, PSNC, that:

Under the current and new terms of service a pharmacist is required to dispense with reasonable promptness, **all prescriptions for drugs** (which includes methadone and buprenorphine), other than drugs listed in the prescription of drugs regulations (e.g. 'black-listed' medicines). However, there are some exceptions as now formally stated in the new contract (SI 2005 No 641) which came into force on 1st April 2005. This allows pharmacists to refuse to dispense or supply if the pharmacist believes that person is not the one named on the prescription form. Supply can also be refused if the pharmacist believes the prescription contains a clinical error or that it is clinically inappropriate. In addition, prescriptions can be refused if the patient or anyone with them behaves, or threatens to behave violently or threatens to commit a criminal offence. The pharmacist also, may not have the drugs immediately available in stock. The situation in Scotland with devolved health boards may be somewhat different.

So our article in issue 10 is misleading (…we got it wrong).

With regard to a Supervised Administration Service, this will be an enhanced service, and therefore pharmacists can opt in or out of supervising misused drugs administration subject to the PCT commissioning the service. Effectively supervision is voluntary and pharmacists can refuse to undertake it.

Update on crushing buprenorphine

Are pharmacists covered by their professional indemnity insurance if they crush and administer buprenorphine?

'The NPA [National Pharmaceutical Association] has agreed to provide indemnity cover to members providing a crushed Subutex service providing a protocol is followed.

Subutex (buprenorphine) is used as an adjunct in the treatment of opiate dependence. Subutex is a sublingual formulation which takes minutes to dissolve. This leads to the risk of the tablet being removed for injection or sale.

To speed the dissolving process, prescribers and pharmacists have crushed the tablets. The instances of crushing are on the increase.

But crushing Subutex is "off licence" and so the manufacturer is unwilling to recommend or endorse the crushing of tablets. Their view is that no studies have been carried out on the impact of crushing the tablets. Crushing increases the surface area of the drug and will thus increase the dissolution and absorption of the drug. On the other hand, crushing increases saliva production which will enhance the possibility of swallowing unabsorbed drug therefore reducing slightly its blockade effects. An increasing number of National Pharmacy Association (NPA) members are now involved in the provision of a crushed Subutex service and are contacting the NPA to enquire whether the NPA will provide professional indemnity cover. The NPA will provide PI cover for members providing this service (and for anyone employed or engaged by the member). However this cover is conditional upon compliance with a "model protocol" developed by the NPA.'

Press Release issued by the Royal Pharmaceutical Society of Great Britain dated 29th March 2005 quoting National Pharmaceutical Association. It refers people to the NPAnet intranet service for details of the NPA protocol.

Dr Fixit on childcare

Sara is a 27 year-old woman who came to see me for the first time having recently joined the practice. She told me that she has been injecting heroin for the past 5 years. She also uses crack cocaine as a treat and has taken diazepam for years, but does not see that as a problem. She also smokes but does not drink.

She lives with her partner John who also uses drugs, and with her 7 year-old daughter Rose. Sara was not using except for the occasional diazepam when Rose was born. Since moving into the area over 3 years ago, the family has been in temporary housing awaiting permanent accommodation.

Sara tells me that she has been in treatment a couple of times before but that she never stayed for long because she did not engage well with treatment. She was also worried they would take Rose away from her because of her drug use.

I have now met Rose and she appears well cared for and sociable but I'm slightly concerned she seems not to have good behavioural boundaries.

I am very comfortable about getting Sara into treatment and will recommend that John comes in too. However, I am unsure how much I should investigate Rose's care, especially in light of Hidden Harm and the Victoria Climbie enquiry.

Can you help me?

Answer by Annie Darby and Kate Halliday

Thank you for this important question. You are happy managing Sara's treatment and are set to include her partner John. However, you are right to have Rose's needs in mind when considering their treatment plan.

The report 'Hidden Harm' sees getting parents into treatment as one of the biggest positives you can do to help Rose's life. We know from Hidden Harm that the more risky Sara and John's drug use is, the more likely the potential harm to Rose.

The report also identifies a number of other parental social and drug using risk factors that should be thought about when considering Rose's care. We know Sara and probably John are both drug users using a number of drugs intravenously and that the family is in temporary housing having moved several times. However Rose seems well cared for and appears to have a good relationship with Sara, although she may not have as strong behaviour boundaries as you would like.

The family may need some support and it appears that Rose is not at any immediate risk. However you cannot be sure of this and some investigation is necessary. We don't actually know what is happening at home such as: whether drug taking in occurring in the home in front of Rose (by her parents and / or others); whether Sara's crack, diazepam or heroin use means that she is unable to look after Rose's needs at times; whether there is injecting equipment left around the home etc; whether there are financial difficulties and also how Rose is doing at school.

Now is the time to involve other professionals in the care of the family, never think you need to do it alone. The school can be a helpful first stop with a simple enquiry of how Rose is doing at school, any concerns and her attendance record. The School Nurse can be invaluable, especially in regard to monitoring Rose's health and welfare, supporting the parents around boundaries and 'Positive Parenting'.

The Family Health Visitor is useful when the child is under 5 years old but most then transfer the care to the school nurse. The Health Visitor may remain involved in a case such as this and may have family background information to share. If you are lucky enough to have access to a Specialist Health Visitor (such as me, Annie), this type of work is our 'bread and butter'. Unfortunately there aren't many of us around! An assessment by a drug worker may also help to build up a fuller picture of the family's needs.

If there is a lack of information about Rose and / or there are any concerns, then it is best to involve Social Services early. Stress to Sara and John, that this involvement does not equate to registration of Rose, or mean that they are going to take Rose into care. Social Services need to be seen as an agency which can undertake an enquiry and offer support. If the enquiry produced no problems then the involvement would cease. They may manage Rose as a 'Child in Need' and can offer help with childcare issues as well as help with housing etc. If there is a Sure Start service in the area, although the age limit is five years, they will have information about child and family support services in the area.

You also rightly mentioned 'The Victoria Climbie Inquiry'. This very much found that professionals involved with Victoria were not assessing or planning together, knew little of each others involvement and these factors failed to protect her. So throughout this process keep talking to Sara, retain her in treatment and always be honest about who else you are talking to and why. If on your enquiries you find problems, discuss them with Sara and John. Sadly some Social Services equate parents using drugs and /or alcohol automatically with being a bad parent, which is not true. It is essential to not assume that using substances will invariably have a negative effect on parenting. However, we do need to recognise if and when Sara and John's drug use is impacting negatively on Rose and how to intervene effectively. If you are in any doubt, then always seek further advice.

Hidden Harm – see article on pages 2-3

NEWS DIGEST

New bill means more coercive treatment

The Drugs Bill gained Royal Assent on the 7th April. This legislation allows for an extension of coercive treatment with mandatory testing for heroin and cocaine for all arrestees suspected of using these drugs or committing specific trigger offences (e.g. burglary). This will be followed by mandatory assessment and treatment should they test positive. Failing to attend assessment will be an imprisonable offence (NB this will apply even if the person was never subsequently charged with the original offence). Other notable measures include the criminalising of liberty cap mushrooms in their natural state, they will now be class A drugs. On a more positive note section 8(d) has been repealed which removes the fear of arrest for those working with drug users for allowing or 'suffering' premises to be used for drug taking, the section which led to the notorious 'Wintercomfort' case. View Release's analysis of the bill on http://www.release.org.uk/news/drugs_bill%20final.pdf

Dr Fixit on Hepatitis C

Dear Dr Fixit

Gary is a 32 year-old patient of mine and he has known that he is hepatitis C positive for at least 6 years. He is stable on a methadone script of 100mg but continues to inject about 1-2 times / week. He has always resisted investigations for his hepatitis C because he was worried about having a liver biopsy and thought treatment would not help. He used to drink but has not done so for the past 4 years.

He recently came to see me complaining of tiredness and lack of energy and wanted to discuss treatment. His friend has also informed him that treatment has improved.

He would prefer to have as many investigations as possible in the surgery. I have already checked his hepatitis status. He is immune to HAV and HBV and positive to HCV. His liver function tests are grossly normal except for a slightly raised GGT and a slightly low albumin.

What further investigations can I do in the surgery and what can I tell him about treatment?

Answer by Graham Foster

Investigations:

1 – Ensure that the following investigations have been recently performed:-

- FBC, LFTs, U and E, Glucose, Thyroid function tests, Clotting screen and alfa-fetoprotein

2- Consider his risks for HIV co-infection – in some areas the prevalence of HIV in injectors is rising and, if he is willing, it may be appropriate to test Gary for this infection.

3- An ultrasound of the liver and biliary tree should be arranged

4 – If possible viral genotyping should be performed but not all GPs have access to this test.

Treatment

Treatment is available for patients with chronic HCV and is effective – over 50% of patients achieve a sustained virological response (i.e. the virus disappears, the liver improves and the response will, probably, be life long). Treatment will be necessary for between 24 and 48 weeks (depending on viral genotype) and will involve weekly subcutaneous injections of a long acting interferon along with 4 to 6 pills that need to be taken every day. Interferon therapy is associated with side effects but the majority of patients manage to overcome the problems and complete the course. It may be helpful to explain to Gary that if he finds the treatment intolerable he can stop at any time.

Treatment is available for patients who are stable on methadone and is now available for stable injectors. Gary should be warned that different units have different policies on treating active injectors and he may have to 'shop around' to find a unit that is willing to offer him therapy.

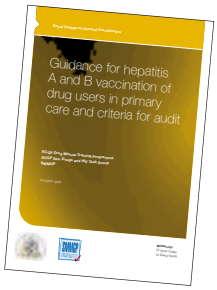
Prior to therapy Gary may be asked to see a psychiatrist or a psychologist as interferon can induce depression and many units formally assess the risk of depression prior to therapy. Most doctors recommend that a liver biopsy should be performed prior to starting treatment and there are advantages to this – it allows that doctor and patient know exactly how much damage has occurred and helps to decide the urgency of therapy. However a liver biopsy is not essential prior to starting treatment. If Gary does not want to have a liver biopsy he should make this clear and should discuss the issue with the doctor that he sees at the hospital. Attending hospital is always slightly intimidating and Gary should be encouraged to take along a friend. It may be helpful for Gary to write down a list of questions before attending the clinic.

Review of key new information on hepatitis C

Graham Foster

- Previous data implied that 30% of hepatitis C positive patients would develop cirrhosis in a 30-year period. There are now concerns that the disease accelerates with advancing age and it seems probable that most patients with hepatitis C will develop cirrhosis long-term.
- Chronic HCV is worse than we thought.
- The older you get the worse it gets (compare smokers) – over 60 years most have developed problems.
- Early reports suggest that the disease may be worse in Asian patients – in elderly Asian patients with chronic HCV nearly all have cirrhosis.
- Who should we treat for HCV? Current NICE guidelines restrict therapy to patients with biopsy proven moderate/severe disease but this is currently under review.
- We need to and can treat patients who are worried about transmission or who are symptomatic.
- Current therapies allow us to 'cure' more than half of our patients – this is a dramatic change from 5 years ago.
- Treatment has improved with pegalated interferon and increased doses of ribaviran.
- The responses to treatment vary by the genotype:
  - Genotype 2 and 3 +/- 78% cure rates
  - Genotype 1 51% with increased ribaviran
- To reduce mortality we need to treat many more patients than we are currently treating – **Graham Foster advocates a 'treat all' policy as therapy is more effective in the young.** Treatment is less effective as you get older.
- Restricting therapy to 'easy' patients is inappropriate.
- Drinking more than 40units / week greatly advances hepatitis C
- HCV post treatment follow up: currently say is virus negative for 6 months then cured BUT slight caution as few HCV has returned post 6 months and these were mainly in people treated with the old interferon
- In general practice before you send for treatment, first check LFT, TFT, Genotype and PCR

Guidance for hepatitis A and B vaccination of drug users in primary care and criteria for audit



The World Health Organisation recommended hepatitis B vaccinations to be included in routine infant and childhood immunisation programmes in countries with high endomicity by 1995 and in all countries by 1997. This recommendation has been adopted in most European countries, the USA and Canada but not in the United Kingdom or Scandinavian countries.

Injecting drug users (IDU's) are at high risk of hepatitis B due to sharing of injection equipment and through sexual spread. It is estimated that 21% of IDU's in England and Wales have evidence of past or current hepatitis B infection. Vaccination against hepatitis B is both safe and effective. IDU's have been targeted in Scotland, England and Wales since 1988 for vaccination. Despite this, both availability of vaccination and uptake by IDU's are recognised to be poor in the UK.

IDU's are also at high risk of developing hepatitis C. All patients with hepatitis C should be protected against the risk of infection with "another hepatitis virus". All IDU's therefore should be vaccinated against both hepatitis B and hepatitis A. Because all drug users have the risk of becoming injecting drug users, at the very least all drug users presenting to drug services should be vaccinated against hepatitis B.

The guidance for hepatitis A and B vaccination has been written and published by the Royal College of General Practitioners to assist all services involved in this field with effective vaccination programmes.

Summary of Recommendations

- Vaccinate **all** drug users against hepatitis B (non-injectors may become injectors).
- **No need** to carry out pre-vaccination testing.
- Use accelerated 0, 7 and 21 day schedule.
- Offer hepatitis B vaccination to partners and children.
- Vaccinate all injecting drug users against hepatitis A.
- Single component hepatitis A vaccine preferable to combined hepatitis A and B vaccine.
- Devise and use an easy recording system to enable audit.

See RCGP Hepatitis guidance: Guidance for Hepatitis A and B Vaccinations of Drug Users in Primary Care and Criteria for Audit, Dr Emer Coffey and Dr David Young http://www.rcgp.org.uk/drug/docs/hepAB.pdf

Paper Review

Incidence of Hepatitis C Virus and HIV among new Injecting Drug Users in London: Prospective Cohort Study

Ali Judd, Matthew Hickman, Steve Jones, Tamara McDonald, John V Parry, Gerry V Stimson, Andrew J Hall

Cite this article as: BMJ, doi:10.1136/bmj.38286.841227.7C (Published 12 November 2004)

What is already known on this topic

Inspecting drug users are at high risk of acquiring HIV, hepatitis C virus, and other bloodborne infections.

What this study adds

The incidences of hepatitis C virus and HIV among new injecting drug users in London are 41.8 and 3.4 cases per 100 person years, respectively.

Participants, method and results

In 2001, 482 injecting drug users (from London) aged below 30 years completed interviewer administrated questionnaires. They provided oral fluid specimens and optionally dried capillary blood spots, for testing for antibodies for hepatitis C and HIV. The participants were followed up after a period of 12 months achieving 70% overall follow up rate. The incidence of antibody to hepatitis C was 41.8 per 100 person years and of antibody to HIV was 3.4 per 100 person years.

Comment

These high incidences of hepatitis C and HIV are corroborated by ongoing surveillance data and suggest that transmission may have recently increased. There is a higher incidence of hepatitis C among injecting drug users in London than in many cities throughout the world. Injecting drug users from London also have an incidence of HIV that is comparable to that of men who have sex with other men who are attending clinics for sexually transmitted infections. Possible explanations for this include changes in pattern of injecting drug use and increases in the size of the population of injecting drug users over and above increases in protective interventions. Innovative strategies that are specific to hepatitis C and HIV are clearly needed to change behaviour and to deliver health education messages and harm reduction strategies early enough to make a difference.

Is your area not providing appropriate hepatitis C treatment?

At the recent RCGP special interest master class on advancements in hepatitis C it soon became apparent that the majority of people working in primary care do not have access to the dramatically improved hepatitis C treatments for their patients. Stories of drug users not being referred, being refused treatment and being told there is nothing to worry about were commonplace.

SMMGP and RCGP SMU are trying to coordinate a response to this disgraceful paucity of treatment and would like your help. Can you write or email regarding any areas where there is notably good or poor practice. Email Jo Betterton, aic99@dial.pipex.com Thanks from Prof Graham Foster, Chris Ford, Jo Betterton and David Young.

BULLETIN BOARD

Social policy and drug users – the implications for primary care

RCGP Certificate in the Management of Drug Misuse

Tuesday 12th July 2005, venue TBC in Sheffield. A day to help primary care professionals review and assess the impact of social policy on their practice. **The day will cover:** pregnancy; childcare and child protection; children with drug using parents; housing and homelessness; benefits. **Speakers include:** Annie Darby-Specialist Health Visitor Substance Misuse (NE Lincs PCT); Mary Hepburn-Obstetrician (Glasgow); Katie Swaine-Legal Advisor (Release). **Cost is £60** for past and current certificate applicants/graduates and **£75** All other delegates. Please note payment is required by 10th July 2005.For further information please contact: Terri Myers, 020 7173 6090/6093 or tmyers@rcgp.org.uk, RCGP, National Drug Misuse Training Programme, Frazer House, 32-38 Leman Street, E1 8EW.

Update on hepatitis and HIV infection

RCGP Certificate in the Management of Drug Misuse

Tuesday 19th July 2005, venue TBC in Manchester. **A day to update primary care professionals on HIV infection and Hepatitis.**

- Did you know that HIV infection in drug users is on the increase?
- Do you want to know the best regime for hepatitis B vaccinations?
- Are you up to date with the latest hepatitis C treatments?

If you are concerned about any of the issues that these questions raise, then this day is for you. The event will also include the launch of the **'Guidance for hepatitis A and B- vaccination of drug users in primary care and criteria for audit'. Speakers include:** Dr David Young – Clinical Director, Drugs and Alcohol, Cheshire and Wirral Partnership Trust. Prof Graham Foster – Hepatologist, London Hospital. **Cost is £60** for past and current certificate applicants/graduates and **£75** All other delegates. For further information please contact: Terri Myers, 020 7173 6090/6093 or tmyers@rcgp.org.uk RCGP, National Drug Misuse Training Programme, Frazer House, 32-38 Leman Street, E1 8EW.

RCGP Part 1 Certificate in the Management of Drug Misuse

Congratulations!

Congratulations to all 327 GPs who at the end of the first year managed to obtained a full Part 1 Certificate in the Management of Drug Misuse. You are all eligible to go on and register with the RCGP Substance Misuse Team for the Part 2.

Thank you to all those who were involved in organising and running a local face- to -face day, the feedback that we have received has been excellent.

The dates for the coming national Part 1 events are as follows:

8th June – Cambridge
21st June – Middlesborough
21st September – Maidstone
9th November – London
25th January 2006 – Location TBC

For further support or information please contact :

Part 1 Certificate - Mark Birtwistle at SMMGP, mark@smmgp2.demon.co.uk, 0161 772 3546

Part 2 to the Certificate – Martin Thompson at the RCGP SMU, mthompson@rcgp.org.uk, 020 7173 6092

Ian Smith posthumously receives the Tom Waller Award

The Tom Waller Award for outstanding services to harm reduction was awarded this year posthumously to Ian Smith who died of liver cancer in October 2004. Readers may remember his brilliant presentation at the RCGP conference entitled 'Scum pudding - society gets the Junkies it deserves' and also his editorship of 'Monkey' magazine and his book 'Heroin Century'. He was a truly radical humanist with an irreverent sense of humour. Whilst acknowledging life was unfair he constantly struggled to improve it for others. He believed that those at the bottom are not there because they deserve to be there or because of some natural order – that their status should be questioned and changed. For those of us lucky enough to know him he was an inspiration as well as the nagging voice of our conscience. He will be sadly missed but definitely not forgotten.

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NETWORK NEWSLETTER

IS SPONSORED BY

SCHERING-PLOUGH LTD

Network ISSN 1476-6302

SMMGP works in partnership with

Trafford Substance Misuse Services

NHS
National Treatment Agency for Substance Misuse